ADDP Association of Developmental Disabilities Providers

Community for Living. Community for Life.

January 29, 2016

Health Policy Commission (HPC)
Attn: Catherine Harrison
50 Milk Street, 8th Floor
Boston, MA 02109

Re: Proposed Accountable Care Organization (ACO) Certification Standards

Dear Ms. Harrison,

Thank you very much for taking the time to consider our comments regarding your proposed ACO Certification Standards. As you may already know, ADDP represents 130 human service providers who provide services for individuals with intellectual and developmental disabilities (I/DD) and to individuals who have both acquired brain injuries (ABI) and traumatic brain injuries (TBI). ADDP is very appreciative of your consideration of our collective concerns to establish standards that will achieve the best framework for providing health care, services and supports paid for by the Commonwealth's Mass Health program and ensuring the best service model for the individuals we serve. For your convenience, ADDP will provide comments in the format that you provided in your official 'Request for Public Comment.'

LEGAL AND GOVERNANCE STRUCTURES (ACO BOARD & SUPPORTING COMMITTEES):

Mandatory Criterion Comment #3: The ACO governance structure includes a **patient or consumer representative.** The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO governance structure. ***Describe and give examples of meaningful participation. What evidence should the HPC seek to assess/evaluate meaningful participation (for our population(s))?***

ADDP strongly supports that Medicaid ACOs provide 'meaningful participation' by ensuring that opportunity is given for representation for the providers who serve individuals with I/DD, ABI and TBI and that representation is significant and both recognizes and reduces any barriers for participation in this process. Meaningful participation should allow the representative to be a voting member of the governance committee and attend governance meetings, as well as be provided with needed transportation assistance, assistive technology and other communication supports for individuals with related disabilities, and all other ADA accommodations should be

offered as necessary. Participation should be assessed through a simple annual survey conducted by HPC. The same survey could be used to assess participation by PCP providers and other specialist providers.

Mandatory Criterion Comment #5: The ACO has a **Patient & Family Advisory Council (PFAC)** or similar committee(s) that gathers the perspectives of patients and families on operations of the ACO that regularly informs the ACO Board.

ADDP urges that Medicaid ACOs do not use existing PFACs (such as those that currently may exist in a hospital) to make sure that PFACs are developed to ensure that people with I/DD and brain injuries receive adequate representation.

RISK STRATIFICATION & POPULATION SPECIFIC INTERVENTIONS:

Mandatory Criterion Comment #8: Using data from health assessments and risk stratification or other patient information, **the ACO implements one or more programs** targeted at **improving health outcomes for its patient population. At least one of these programs addresses mental health, addiction, and/or social determinants of health.** ACO **annually evaluates the population health programs** in terms of patient experience, quality outcomes, and financial performance. ***Should the HPC be more prescriptive with this requirement (i.e., require more than one program?)***

ADDP believes the scope of the programs should be addressed with a minimum population defined while still recognizing the specific needs of the I/DD, ABI and TBI populations and providing adequate choice of services. Providing very prescriptive evidence of such programs may likely cause an additional burden/cost to providers.

CROSS CONTINUUM NETWORK: ACCESS TO BH & LTSS PROVIDERS

Mandatory Criterion Comment #9: The ACO demonstrates and assesses effectiveness of ongoing collaborations with and referrals to: 1.)Hospitals 2.)Specialists 3.) Post-acute care providers (i.e., SNFs, LTACs) 4.) Bx. Health Providers (both mental health and substance use disorders) **5.)LTSS providers (i.e. Home Health, Adult Day Health, PCA, etc.)** 6.) Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.) ***What evidence should the HPC seek to evaluate whether ACOs assess effectiveness of the collaborations?***

ADDP members have expressed that the tracking of additional data sets such as collaborations will be burdensome for providers who serve patients in multiple ACOs and/or patients of other payers. Collaboration should be assessed by tracking the utilization of and dollars spent on various service types each category of ACO partners listed above. If the system is working the pattern of utilization and funds should indicated reduction of avoidable acute hospital and emergency services with maintenance or increases in community based services.

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Mandatory Criterion Comment #10: As appropriate for its patient population, the ACO has capacity or agreements with mental health providers, addiction specialists, and LTSS providers. Agreements should reflect a categorized approach for services by severity of patient needs. These agreements should also include provisions for access and data sharing as permitted within current laws and regulations.

ADDP members have also expressed that this is an appropriate standard. However, the existence of an MOU or a contract is not a guarantee of referral or service use, as has been evident in the One Care Demonstration. If the objective is to ensure effective use of specialty community providers such as I/DD and mental health providers, addiction specialists and LTSS providers then tracking dollars that are spent in conjunction with the utilization of services is far more effective and efficient.

PARTICIPATION IN MASS HEALTH APMs

Mandatory Criterion Comment #11: The ACO participates in a budget-based contract for Medicaid patients by the end of Certification Year 2 (2017) ***Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).*

Budget-based contracts require good, timely data and robust quality/outcome measures. The current system has made the receipt of good, timely data particularly challenging for I/DD, behavioral health and LTSS services. The limitations in obtaining timely, quality data should be strongly considered when setting these goals for APM adoption.

ANALYTIC CAPACITY

Mandatory Criterion Comment #13: The ACO regularly performs cost, utilization and quality analyses, including regular trending and forecasting of performance against budget and quality measure targets, and works with practices and providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house. ACO disseminates reports to providers, in aggregate and at the practice level, and makes practice-level results on quality performance available to all participating providers within the ACO. Is this a feasible requirement for smaller ACOs?

ADDP believes this requirement is essential for any successful ACO, and that all ACOs must meet this requirement. Unfortunately it has been clear from the One Care Demonstration that Plans have not produced public reports on data and analyses of utilization of services or funds by types of services to either Mass Health, the One Care Implementation Council, or in any public forum.

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Mass Health is reportedly attempting to aggregate and analyze raw data submitted by the Plans on utilization and funds flow data – but this is years into the Demonstration. This variable needs to be taken very seriously throughout this implementation process by ensuring that proper reporting on this data occurs and that the analyses are being performed as required.

ADDITIONAL MANDATORY CRITERIA FOR MEDICAID ACOs:

Financial Capacity/Stability

Medicaid ACOs need to show that they have the financial capacity and stability to implement and sustain the system change and service development required to establish and operate an effective network.

IT infrastructure

Medicaid ACOs must have minimum capabilities for connectivity, interoperability and real time communication between its provider networks. Operating a successful ACO will be impossible without these capabilities.

Authorization to share information

Medicaid ACOs must demonstrate that all providers in network are able to access patients' documentation for authorization to share information.

Ombudsman/Grievance Procedure

Medicaid ACOs need to have a robust patient protection system including ombudsman and appeals process. Requirements could be based on the One Care model.

Thank you very much for taking the time to consider the concerns of ADDP, and understanding that what is proposed and requested is a reflection of wanting to adhere to best practices and apply the best approach for serving individuals with developmental disabilities and brain injuries.

Thank you very much for your time and consideration.

Best regards,

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